b. *Cases in which the Tumour could not be removed.*

Mrs. P.—Very large malignant mass, inseparably adherent posteriorly. Extreme suffering from distension by solid matter, and rapidly approaching death, rendered the attempted operation justifiable. Died on the following day. Present, Dr. Rigby and others.

c. *Cases in which small incisions have been made, either to determine the existence of adhesions, or to remove unusually viscid secretions.*

Mrs. P.—Small incision, then tapped. Present, Dr. Ansell, Mr. May, and others. Is now living.

——. Small incision, then tapped. Present, Dr. H. Roe, Dr. Wilks, and others. Is now living.

Miss ——. Incision of rather larger size. Present, Mr. Coulson, and others. Lived two years.

Mrs. C.—Small incision, to ascertain character of adhesions, and of small tumour attached to the cyst, as well as to evacuate contents. Present, Mr. Huxtable and others. This patient was advanced in life, and exhausted by suffering. Lived six weeks.

Miss G.—Incision. Present, Mr. Streeter, in whose practice it occurred. Lived more than two years.

Mrs. B.—Incision, then tapped. Present, Dr. H. Roe, and others. Lived nearly three years.

Miss B.—Incision, then tapped. Present, Dr. Murphy, Dr. Snow, and others. Lived six months.

Miss B.—Incision, then tapped. Present, Dr. Rigby, Mr. B. Holt, and others. Is now living.

A. B.—Incision, then tapped. Tapped several times afterwards. Present, Mr. Chance, and others.

——. Incision, then tapped. Tapped afterwards. Present, Dr. Rigby, Mr. Holt, and others.

Mrs. S.—Incision, then tapped. Tapped many times afterwards. Present, Mr. Holt.

Mrs. C.—Incision, not tapped. Afterwards tapped, and died. Present, Mr. Streeter.

Miss G.—Incision, to ascertain adhesions, and to remove very viscid contents. Present, Mr. Smith, Mr. Holt, and others. Died next day from bursting of a large hepatic abscess into peritonæal cavity, as proved by autopsy.

Mrs. C.—Small incision, then tapped. Subsequently tapped, and was living more than a year afterwards.

S. R.—Incision; colloid. Present, Mr. West and pupils. Was living after the lapse of ten months.

Mrs. W.—Small incision, then tapped. Present, Mr. Huxtable. Tapped many times afterwards.

L.—Incision, then tapped. Present, Dr. H. Roe, and others. Was living a year afterwards.

Miss S.—Incision, then tapped. Present, Mr. Mosgrove and others. Now living.

Conclusion.—I have thus extirpated large ovarian tumours in thirteen cases, of which number nine were successful, four unsuccessful; in one case the tumour could not be extirpated, and the patient sank. In eighteen other cases, I have made small incisions, as a means of diagnosis or relief, and in no case did a bad result ensue from such incisions, leaving a total of thirty-two cases, in the treatment or investigation of which the abdominal cavity has been incised. —*Ibid.*

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31. *On the Treatment of Sprains of the Ankle.*—M. Baudens observes that, judging by the frequency of the occurrence of this accident, its treatment ought to be well understood and successfully practiced; but that this is in fact far from being the case, and he is therefore desirous of making his own plan of treating it, by the cold-bath and gum bandage, more extensively known.

The indications are, first, to prevent or remove inflammation, and then to secure immovability to the distended or lacerated parts, until they have recovered their power, the patient being at the same time allowed the use of the limb. For the purpose of subduing inflammation, numbers of leeches are usually applied, and then an emollient cataplasm; and M. Baudens feels convinced that it is in consequence of such treatment that degenerated sprains so often augment the number of amputations in hospitals. By free leeching of a joint, the seat of sprain, two mischievous effects are produced. In the first place, the pain, which is the first of the series of symptoms of inflammation after sprain, is increased by the leech-bites, in place of being mitigated; and, in the next, the increased afflux of blood towards the part is encouraged instead of being repelled. M. Baudens, on these grounds, strictly forbids the application of leeches in all surgical maladies attended with acute inflammation, while he often derives most excellent aid from their employment in chronic inflammations; thus, by the induction of a temporary congestion, giving a fillip to the too languid action of the part. When blood need be taken in sprain, he abstracts it by venesection, although probably both the profession and the public, from the force of habit, would tax with ignorance any one who neglected the use of leeches. As to emollient cataplasms, they favour in place of opposing the afflux of fluids to the part, while the long maceration the joint has been thus submitted to deprives it of its elasticity, gives rise to a pasty *engorgement*, and predisposes to the formation of white swelling.

M. Baudens has pursued his own plan of treatment now for twenty years, and under it his patients have been enabled to resume their trying military duties in a very short time. He is not the first who has employed cold water in the treatment of sprain; but his originality consists in trusting to it alone, and continuing its application for so long a period. His plan of employing it, contrasted with that of his predecessors, may be thus summed up:—1. *Period of the application.* Cold has usually been thought desirable only when it could be resorted to very shortly after the accident; but he applies it not only immediately, but also several hours or days after the occurrence, or even in chronic sprain—whenever, in fact, there is a *morbid degree of heat to abstract.* 2. The local bath has never been ordered by others for longer than five or six hours, although some practitioners, since his first publication on the subject, have ventured to extend it to twenty-four. In certain of his cases, however, immersion has been continued for eight or ten days, and, in one example, for fourteen days; while in no case has it been less than for two. 3. *Mode of application.* The vessel containing the water is brought to the bedside of the patient, so that he can conveniently place his leg in it, having the heel resting on a sponge at the bottom, the leg and thigh being supported by cushions, so that the position may be maintained for as many days as required. In the vessels used at the Val-de-Grace, the water reaches as high as the middle of the leg, and is changed about every three hours in order to keep it sufficiently cool. Spring-water is usually employed, and if the inflammation is intense, ice is added. A purgative is given, and, if indicated, one or two bleedings are resorted to. 4. *Effects.* —One of the first of these is the cessation of pain, which sometimes occurs at once, and at others in an hour or two. From the moment the foot is placed in the bath, the swelling becomes stationary, and soon after, with the heat and redness, decreases. About the fourth or fifth day the part becomes wrinkled like the hands of a washerwoman; and usually about the third or fourth day the patient finds the water too cold, and then the limb is removed from it—the period for doing this being regulated by the patient, he being told to keep it in only as long as he derives comfort from so doing. Few of the patients suffer from any general reaction. *Gangrene* has been said to have resulted from this application, but the author has never met with such a case. The patient sometimes persists in keeping the limb in water after the dispersion of the heat and pain, and the consequence is the production of engorgement of the joint, a tense state and dark colour of the skin, together sometimes with darkish lines—precursory signs of congelation in fact—on seeing which the joint should be enveloped in a fomentation of elder-flowers and poppy-heads at the temperature of the atmosphere. The objections which have been urged, from the fear of producing *repercussion*, are quite theoretical and unfounded. It is, in fact, only the *excess* of *morbid caloric* that is abstracted.

Gum-bandage.—When the inflammation has been subdued, all the depressions, in the vicinity of the joint are filled with wadding, and a bandage carefully and equably applied. This is well moistened by means of a brush with very thick gum, which in a short time imparts to it almost the hardness of wood. After this has been worn for twenty-five or thirty days, it is removed, and the joint slowly and gradually exercised; for want of which precaution many patients (especially those treated by leeches and poultices) suffer all the symptoms of a sub-inflammation of the white tissues of the joints, even for years.—*Brit. and For. Med.-Chirurg. Rev.*, Oct. 1850, from *Gazette des Hôpitaux*, 1850, No. 506.

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32. *Dislocation of the Scaphoid Bone of the Foot.*—Dr. Walker records in the *Provincial Med. and Surg. Journ.*, Oct. 16th, 1850, the following example of this very rare accident.

"On the 10th of June 1850, a stone mason, aged 40, and of a spare but sinewy form, in stepping from the top of a wall, eighteen feet high, to another about a foot lower, over an intervening space of about two feet, advanced his right foot, but stepped short, his toes only resting upon the wall, his whole weight being, in the act of stepping, thrown upon the right leg. The foot, as he says, "bent upwards, and something gave way." Falling down between the two walls, he found himself on the ground on his hands and knees, not hurt, as he conceived, by the fall, but quite unable to work, and his foot in great pain. He was carried home, and I saw him next day. He was in bed, and on examination my opinion of the case entirely coincided with that of Mr. Hanbury, our excellent house-surgeon, who had previously visited him. We found a bold projection on the dorsum pedis, in the situation of the os naviculare, and a corresponding depression beneath, where, in the normal condition, the tuberosity of this bone forms a distinct projection. Over the displaced bone the skin was tense and red, and over this point there was a good deal of pain on pressure. He could bend and extend the ankle-joint without difficulty or much increase of pain. I at first tried to reduce the bone by firm pressure with the thumbs, but it felt firmly fixed in its abnormal position, and I could not move it.

"I then requested Mr. Hanbury to press the foot downwards, whilst I attempted to return the bone to its position between the astragalus and cuneiform bones, and with an audible snap it returned, and the deformity disappeared.

"I then merely directed the foot to be kept quiet and fomented; but two days after, finding that the bone felt loose and easily movable, with a tendency to slip upwards, occasioning the peculiar appearance of a slight dimple or hollow in place of its natural projection, a plaster and roller were applied.

"He was confined to the house for three weeks. He then returned to his work, but continued slightly lame for about a month after. This morning (Sept 16th) I find, on examination, no remaining appearance of injury; he has no pain, and the motions of the foot are perfect."

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33. *Ununited Fracture of the Tibia of twenty-four years' standing successfully treated.* By R. W. Tamplin.—Patient a young woman, aged 25; leg broke at lower-third in infancy. The fracture neglected for some years, and then a variety of treatment adopted to promote union, without success. The case was given up as hopeless, and amputation recommended by surgeons of eminence. When Mr. Tamplin saw the patient, the leg was two inches and a half shorter than the other, the upper portion of the tibia projecting pointedly forwards, and riding over the lower third; there was free movement at the point of fracture. Mr. Tamplin had an instrument so made that the thigh could be firmly grasped above the condyles of the femur, the foot below having a screw, by means of which the distance between the knee and the foot could be gradually increased. This was applied on the 31st of July, 1849, the leg kept horizontal in the extended position. Gradual extension was now commenced, and continued for four days. So much pain was occasioned in the gastrocnemius that it was found necessary to divide the tendo-Achillis. From this time the leg became gradually and easily elongated, and during the extension a steady continued

pressure was kept up on the tibia, above the point of fracture, and counter-pressure at the back of the leg, just above the ankle-joint. This treatment was persevered in unremittingly until the 9th of January, 1850, without interruption to the health, when the leg was found to be of equal length with its fellow, and the bone retained its position unassisted. Common splints, with a boot attached, were used to support the limb. On the 26th of February she could raise the leg to the horizontal position. On the 3d of April she could stand and walk without pain or sign of motion at the point of fracture. Since that time had continued to use the leg freely; could walk up and down stairs; her general health had improved, and there was every reason to believe that a perfect cure had been effected.—*London Med. Gaz.*

34. *On Primary and Secondary Amputation.*—Dr. **Restelli**, one of the surgeons in chief of the Sardinian army, in relating the surgical history of the late campaign, confirms the opinion now generally entertained by military surgeons of the preferability of primary amputations by the following statistical statement, which, although on a small scale, is very conclusive. He says that whenever an operation becomes recognized as one of undoubted necessity, he believes it the best practice to perform it at once (that is, within thirty-six hours after the injury) in place of waiting the development of fever, inflammation, and suppuration, with the consequent greater liability to phlebitis, purulent infection, tetanus, visceral inflammations, &c., dangers with which the simple wound from amputation is scarcely to be compared. Acting upon these principles, he obtained the following results:—

	IMMEDIATE AMPUTATIONS.	Recovered.	Died.		CONSECUTIVE AMPUTATIONS.	Recovered.	Died.
1	At the hip-joint .	1	0	6	Middle of the thigh .	1	5
7	Middle of the thigh .	5	2	1	At the upper third .	0	1
4	Upper third of thigh	2	2	1	Upper third of leg .	0	1
3	Upper third of leg .	2	1	7	Upper third of arm .	2	5
10	Upper third of arm .	9	1	2	Shoulder-joint .	1	1
1	Shoulder-joint .	1	0	3	Forearm . .	2	1
26		20	6	20		6	14

Thus in the immediate amputations there was a mortality of about 24 per cent. and in the consecutive ones of 70 per cent.; the fatality of these last especially referring to the lower extremities.—*Brit. and For. Med.-Chir. Rev.*, Oct. 1850, from *Annali Omedei*, vol. cxxx.

35. *Surgical Operations, in reference to the Employment of Chloroform.*—M. **Boyer** considers that surgical operations, in their relation to chloroform, may be thus arranged:—

1. Those in which it is a powerful auxiliary, facilitating their execution, as in the reduction of dislocations and strangulated hernia. 2. Those which are exceedingly painful, in which chloroform diminishes suffering, but does not render the operation more easily executable. They are very numerous, and this is the only point of view in which the public regards the advantage of anæsthetic agents. 3. Those in which it may become an obstruction or preventive to their execution. Thus, a patient of M. Boyer, on whom he was operating for lithotrity, became so restless under chloroform that he could not continue until the anæsthetic influence was withdrawn. 4. Those in which it may prove dangerous, as in cataract. So, too, in tedious and delicate operations performed in the vicinity of important organs; as, for example, ligature of the carotid, during which any indocility of the patient might lead to the wounding of important veins, and in some of the cutting operations in the mouth. 5. Those of a trivial character, in which chloroform is a superfluity, as the slight advantage obtained from its use does not generally compensate for the disagreeable effects produced by the inhalation, such as the smell, headache, and the kind of intoxication that results. 6. There are certain contra-indications to its use in all cases, as acute or chronic affections of the brain, liability to cerebral congestion, great debility, &c. Its employment must, therefore, not

be regarded as a mere matter of course; and surgeons, in order to prevent abuse, may often have to discountenance it.—*Brit. and For. Med.-Chir. Rev.*, Oct. 1850, from *Gazette des Hôpitaux*, No. 51.

36. *Origin of the Epigastric and Obturator Arteries by a common trunk from the Internal Iliac; with an inquiry into the amount of danger occasioned by various positions of arteries in the ordinary operations for Femoral and Inguinal Hernia.* By P. Redfern, M.D. (*Monthly Journ. Med. Sci.*, Sept. 1850.)—In this interesting paper, the author, after describing a case met with by him, in which the epigastric and obturator arteries arose by a common trunk from the internal iliac, and referring to two similar cases, one recorded by Hesselbach, and the other by Dr. Monro, discusses the surgical relations of these deviations.

He reviews, 1st, those varieties of position in which a vessel of considerable size appears likely to be exposed to danger in the performance of ordinary operations, and the frequency of like positions; 2d, in what proportion of such operations vessels of importance have been injured in actual practice, and 3d, the probable result of future cases of injury to these vessels, by a reference to the termination of those which have already been made public.

The conclusions which Dr. Redfern draws from his investigations are:—

1st. In every possible variety of inguinal rupture, the stricture ought to be divided directly upwards, as by so doing there is not the slightest risk of hemorrhage.

2d. The probability of the occurrence of hemorrhage is much greater in operations for femoral than for inguinal hernia, as the epigastric, obturator, or internal circumflex artery may be divided in exposing the sac; and the obturator, epigastric, or a large anastomosing branch, may be injured in the division of the stricture.

3d. The varieties in the arteries named are sufficiently frequent to render them of great surgical importance, and that variety is most important in which the vessel is displaced inwards, by the descent of a femoral hernia, and becomes tensely stretched over the front and inner side of the neck of the sac.

4th. The risk of hemorrhage is not lessened by dividing the stricture of a femoral hernia in any other direction than inwards or upwards and inwards, but it is very much diminished by dividing as few of the tense fibres of the edge of the ring as possible, by avoiding a sawing motion, and by pressing the edge of the knife rather upon the anterior surface than directly on the edge of the fibres constituting the stricture.

5th. In a male, whose testis has passed into the scrotum, the spermatic artery may be wounded, and the testicle lost, by dividing the stricture at the neck of the sac of a femoral hernia upwards, and, therefore, this method of operating ought to be relinquished.

37. *Aneurism of the Femoral Artery, Ligature of the External Iliac.*—Henry Smith, Esq., records in the *Medical Times* a case of aneurism of the femoral artery in a man 37 years of age, in good health and temperate habits. On the 7th of August, Mr. S. applied a ligature to the external iliac, and the patient made a rapid recovery. The ligature was readily withdrawn on the twentieth day, and in five weeks after the operation the wound had healed with a firm and healthy cicatrix.

38. *Ligature of the Femoral Artery for Popliteal Aneurism.*—James Drummond, Surgeon, Dundee, records (*Monthly Journ. Med. Sci.*, Nov. 1850) a case of popliteal aneurism, on right side, in a seaman, 33 years of age, in which he successfully applied a ligature. The incision, except immediately around the ligature, had united in forty-eight hours; the temperature of the limb, which for the first two days was slightly lower than its fellow, was restored on the third day, and the ligature separated on the thirty-first day.

39. *On the Employment of Forced Flexion for arresting Hemorrhage in Wounds of the Palmar Arch.* By M. E. Durwell.—A woman fell from a ladder, having a

bottle in her hand. The bottle was broken, and fragments pierced the palm. M. Durwell, on arriving at the poor woman's cottage, found the palmar arch wounded; and he had no means of securing the artery. While controlling the hemorrhage by pressure on the brachial artery, the following sentence in M. Malgaigne's *Anatomie Chirurgicale* occurred to his mind: "The only points at which obliteration of an artery can be obtained by position alone, without the aid of external compression, are at the bend of the arm and knee—a fact which is of great importance in reference to the arrest of hemorrhage." Acting upon this statement, M. Durwell immediately bent the arm on the fore-arm at an acute angle; the hemorrhage was instantly arrested. Advantage was taken of the circumstance to effect a definite cure. The arm was retained in its flexed position by bandages, so that the pulsation of the radial artery was completely intercepted. The wound of the hand was treated as an ordinary wound, and, for the sake of precaution, compresses were laid over the course of the arteries of the forearm. The cure progressed favorably. On the third day, as the patient complained of the restraint of the posture, the arm was slightly extended, and it was noticed that a small portion of florid thin blood oozed from the wound. The arm was restored to its flexed position, and in a short time the vessels and the external wound had perfectly healed.

In this manner a wound, usually regarded as of a very serious character, was safely and speedily cured by a proceeding as simple and unobjectionable as has ever been proposed. It must be attended with success when employed in analogous cases, and, from its simplicity, should be tried in the first instance in every case. M. Durwell observes justly that it would be rash to make a more general application of a single fact, as there may doubtless occur complications, rendering its employment impossible or unadvisable; but, at the same time, he adds that this principle may be found, by further experiment, to be useful on other occasions, for the obliteration of the popliteal and humeral arteries. This principle he lays down in the proposition—"that in most arterial lesions of the forearm and leg, prolonged forcible flexion supersedes the ligature of the vessels."—*Prov. Med. and Surg. Journ.*, Nov. 13th, from *L'Union Médicale.*

40. *On Hospital Gangrene.* By Prof. RESTELLI.—Between Sept. 1848 and Feb. 1849, hospital gangrene prevailed in the overcrowded Military Hospital of Alessandria to a terrible extent as a complication of wounds, and especially of gunshot wounds; so that above 400 cases came under Dr. Restelli's care.

Owing to the crowded state of the hospital, no classification of patients could be observed; but this gave the author the opportunity of observing that individuals suffering from contagious diseases (as syphilis) were more easily attacked by the gangrene, and that it rapidly produced in them dreadful ravages. No general symptoms usually preceded the alteration of character in the wound; and in some cases the disease continued local in its manifestations, but in several others, remittent fever was present, increasing with the progress of the disease. In some cases, there were daily paroxysms of fever and profuse sweating, simulating an intermittent fever, with which various nervous symptoms, especially those of a convulsive character were conjoined, and were of very bad omen.

In order to prove the contagious character of the disease, the author, most unjustifiable, as we think, inoculated various wounds occurring in different temperaments with some of the matter, and also inserted it subcutaneously in healthy parts. Other proofs were found in its being communicated from bed to bed during the overcrowding of the hospital, and on its having been propagated in the town by means of a dirty knife used in an operation. The author, indeed, regards the propagation of the disease as entirely affected by contact, although he allows that the bad state of the air of a crowded hospital increases the virulence of the disease. He does not believe, however, that any contagious principle capable of propagating the disease is absorbed into the system; and thus, when in consequence of the ravages of the disease, operations or amputations were required, the new surface did not take on gangrenous action, providing care were taken to prevent gangrenous matter obtaining access to it. Taking this view of the disease, it is to local treatment he looks for a curative agent, and this may be had recourse to at any stage, if the part retains sufficient reactive power. After trying experiments with numerous caustic substances, as the strong acids, &c., he has come to the conclusion that the best application is a *solution of caustic potass*, which he considers to act not as a mere caustic, but also by neutralizing the virulence of the poison itself. On the first day, however, he applies pieces of caustic potass in substance to the wound, endeavouring to penetrate into all its sinuosities. Next day the wound is dressed with a solution of ℈j ad ℥j of water, and every day the strength of the solution is diminished by four or five grains, to the fifth day, when the wound is simply dressed. The author declares that even the worst cases went on well after this plan was put into practice. In the subsequent treatment of the wounds, absorbent powders, as charcoal, and especially carbonate of magnesia, were of very great service.—*Brit. and For. Med.-Chirurg. Rev.*, Oct. 1850, from *Annali Omedei*, vol. cxxx.

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41. *On Dry Gangrene.*—Dr. De Martini observes that the seat and cause of progress of spontaneous dry gangrene have not been sought for by pathological anatomists in the primary elements composing the structure of the affected parts, but in some distant points from the centre of the alterations. He is of opinion, however, that all the tissues of a part suffering from it are the seats of a *minute capillary injection, and a total and primary coagulation of the blood.* The most delicate capillaries are injected, they become obstructed with fibrinous coagula, and a portion of the colouring matter is effused around the anastomotic points. The papillary body loses its moistness and rose-white colour, and becomes a collection of black and hard asperities, rising from a dermis that looks as if it were carbonized. Observed through a microscope, these minute vessels seem as if injected by a substance which has hardened within them; and, in fact, so obstructed are they that when divided they do not empty themselves any more than as if they were filled with so much wax. In the adipose layer, muscles, and, indeed, all parts that the gangrene implicates, the same minute capillary injection and coagulation is observable.

In reference to the causes of this complete coagulation in the capillary circulation, the author expresses his opinion that insufficient attention has been paid to *primary lesion of the capillary innervation.* The acute, burning pain preceding the development of the gangrene, the greater disposition of the paralyzed extremity to become attacked, the commencement of the process by a complete arrest and coagulation of the blood in the capillaries (the circulation in which is under the influence of the ramusculi of the sympathetic), and the nervous disorders which frequently precede or accompany the development of the affection, lead to the belief that a primary paralysis of the capillary innervation may frequently play an important part in the induction of this gangrene.

In a *chemical* point of view, the metamorphoses which accompany dry gangrene are quite special. In gangrene, the consequence of inflammation, there is rupture of capillaries and effusion of blood, and thence a more intimate combination of its oxygen with the elements of the tissues. The effused blood coagulates, the globules and darkened hematose dissolve, and the whole organic materials of the fluid pass into a state of decomposition, which is communicated to the surrounding tissues. In dry gangrene, coagulation takes place without prior inflammation, and at the various anastomotic points, effusions forming also coagula are likewise observed. No solution of the blood, no decomposition or disruption of tissues, takes place. The structure of these undergoes little or no alteration. The physical characteristic of *inflammatory gangrene* is the changing of the organic solids into a soft, pultaceous, decomposing mass; while that of *dry gangrene* is the changing of the humours and soft parts into dry solids. The smell of rancid bacon, which the part emits in dry gangrene, and the readiness with which *mycodermes* are developed on the surface, would seem to show that the process is one of slow combustion—*eremacausis*, a process at first excited by the oxygen of the blood, and when that ceases to be obtainable, by that of the air. A foot suffering from dry gangene, which had been amputated, was introduced under a bell containing air, together with some pieces of caustic potassa. In three days the whole of the oxygen had become consumed, and the potass converted into carbonate. The process of *eremacausis* could not be set up in organic matter without prior enfeeblement of the vital affinities of its elements, which are dependent upon the peripheric innervation.

From what has been said, it is evident that the organic changes produced in dry gangrene are incurable, for the coagulated blood cannot resume its organic liquid state, nor can the chemical metamorphosis, affected by means of oxygen, be arrested. But this chemical process does not limit its operations to the gangrened part, since the facility of absorbing oxygen possessed by a part in a state of *eremacausis* is communicated to all matters in contact with it, so that the entire body might become involved in this slow combustion, originating in a part already dead. The indication, therefore, is not to lose time in employing internal remedies, which are always useless, but to at once remove the limb beyond the gangrened part, and then resort to means of rational treatment. Does not the *vis medicatrix* of Nature, which preserves the whole body by a spontaneous separation of a part, teach us this lesson?—*Brit. and For. Med.-Chir. Rev.*, Oct. 1850, from *Omedei Annali*, vol. cxxvi.

42. *On Fungous Tumour of the Rectum in Children, attended with Bloody Discharges.* By M. Leclayse.—M. Martin has already directed attention to the affection as it occurs in the adult, producing discharges which are mistaken for those from hemorrhoids. The first case occurred in a child æt. 5, about whom the author was consulted in consequence of hemorrhages which occurred during a prolapsus ani, and which arose from an excrescence that he at first mistook for hemorrhoids. Examining it more closely, he found it was a spongy vegetation, not unlike a portion of the placenta, which protruded from beyond the sphincter when the child went to stool, and was quite insensible to the touch. As the hemorrhage had been considerable, the fungus was touched with the nitrate of silver whenever it protruded; and owing to its softness, four or five applications, at intervals of several hours, sufficed for its destruction. In a second case, a girl æt. 8 had become much reduced by the quantity of blood she had lost during several weeks; and a fungous tumour, about the size of an almond, was easily removed in the same way. A third case occurred in an infant six months old, in whom efforts at stool protruded a tumour the size of a pea, which bled. The author believing it to be the germ of the fungous tumour, also treated it with caustic.

M. Leclayse believes that this affection is often mistaken for hemorrhoids; and especially when the bleedings are said to be due to internal piles. The caustic could not be applied very high up, but as the bleeding has only occurred on the protrusion of the tumour, this has been easily reached, the application being successful even when the base of the tumour could not be attained.—*Brit. and For. Med.-Chir. Rev.*, Oct. 1850, from *Rev. Médico-Chirurg.*, tom. vii.

43. *Gonorrhœa treated with Acetate of Potash.*—Mr. Hilton has endeavoured to arrest gonorrhœa without the aid of cubebs, copaiba, or other means usually adopted. The medicine he employs is acetate of potash in half-drachm doses. The following cases are selected to exhibit the results of this simple treatment:—

The first case refers to a man, aged thirty, a tailor by trade, who, when admitted, July 24th, into Samaritan ward, had been affected with a discharge for a week; the urine was very acid, and the scalding intense. The day after admission, Mr. Hilton prescribed half-drachm doses of acetate of potash to be taken three times a-day. Five days afterwards, the scalding was relieved, the urine being still acid; on the thirteenth day the scalding, though decreased in intensity, continued, and the urine remained acid; the acetate was therefore ordered to be taken every fourth hour. On the sixteenth day the scalding was trifling, and the urine acid; on the eighteenth the urine became alkaline; the scalding had disappeared, and the discharge had completely ceased for some days. The patients are always kept in the house a little time after its cessation, for fear of a relapse; and on the twenty-third day the patient was quite well, after having taken the acetate of potash three times a-day for thirteen days, and every four hours for five days.

The second case is that of a labourer, twenty-seven years of age; he had

had a gonorrhœal discharge for three weeks when he applied for admission. The treatment began in the same ward (Samaritan), on the 24th of July, as in the preceding case, and the acetate of potash, in an aqueous menstruum, was likewise ordered to be taken three times a-day. The salt is also given with advantage in camphor mixture, and Mr. Hilton often supplies the patients with the acetate in powder, desiring them to dissolve it in water themselves. Here, however, no very material improvement took place for the first fifteen days, when the scalding became less, and the discharge began to diminish in quantity, the urine being acid. Mr. Hilton now ordered the same doses to be taken every fourth hour. On the nineteenth day the scalding continued, the discharge was less, and the urine slightly alkaline. On the twenty-second, the urine became again acid, though the patient was taking the acetate every fourth hour. At this time diarrhœa set in, and the patient was precluded from continuing the acetate of potash. On the twenty-eighth day after admission, however, the use of the salt was resumed; it was taken every four hours for eleven days, when the scalding and discharge were entirely subdued. It should, however, be noticed, that even at this period the urine remained somewhat acid.

Mr. Hilton was led to give the acetate of potash a trial in cases of gonorrhœa from the following considerations: The urethra is in this disease in a highly inflammatory state, and the urine very acid; it is clear that the latter fluid in passing over an inflamed surface must tend to irritate it much, and retard the diminution of the inflammation. The acetate of potash, by its tendency to render the urine alkaline, will therefore remove one of the obstacles which lie in the way of the cure. This same salt has likewise most undoubted depurating properties, and its antiphlogistic powers are very remarkable. Its administration, therefore, will have the double advantage of rendering the urine less acid and irritating, and of reducing inflammatory action all through the system, and as a consequence in the urethral mucous membrane.

Mr. Hilton does not deny the modifying properties of copaiba and cubebs, but he considers that the acetate of potash renders great service in those numerous cases where, from many different circumstances, neither copaiba nor cubebs can be taken. He often uses the latter therapeutical agents when the disease has been subdued by the above-named salt; a few doses of copaiba then complete the cure, and are likely to prevent relapse.—*Lancet*, Nov. 1.

MIDWIFERY.

44. *On the Causes of the Non-success of the Cæsarian Operation.*—Dr. Roubaix, of Brussels, has published (*Encyclographie Médicale*, June,) an elaborate memoir, in which he passes in review various questions connected with this operation. As, for instance, whether the danger of the operation consists in the incisions themselves; whether it is the result of some error in the operative proceedings, or is induced by the circumstances under which the operation is performed; and, lastly, whether, by any modification of operation, greater success can be insured? These are the problems which the author attempts to solve:—

1. *Does the danger of the operation depend on the dangerous consequences of the incisions?* In answering this question, the author divides the tissues incised into three categories—the first comprising the abdominal parietes, the second the peritoneum, the third the womb.

Respecting the first of these he observes that little need be said, as wounds of the integuments of the abdomen do not differ from ordinary wounds; the danger is in the incising the peritoneum and womb.

He further states that, judging by the analogy of other operations in which the peritoneum is interested, we cannot consider the danger to be in the incision of the membrane, as in the case of hernia, and in many severe accidental wounds, the peritoneum is often extensively injured without bad consequences. In the lower animals, the operation of spaying is another instance in point. So also wounds of other serous membranes, as the pleura, are comparatively harmless, as long as the important organs of the chest are uninjured. In the